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Scottsdale, AZ 85251

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Clinical Psychologist

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### Intake Information for Minors

#### Child Patient Information

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_  
Referral source (name) \_\_\_\_\_  
Medical or Psychiatric Conditions \_\_\_\_\_  
Medication(s) \_\_\_\_\_ prescribed by \_\_\_\_\_

#### Parent Information

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Telephone (1) \_\_\_\_\_ (2) \_\_\_\_\_ (email) \_\_\_\_\_  
Others who have legal custody rights: \_\_\_\_\_ Any history of abuse? \_\_\_\_ yes \_\_\_\_ no

**Insurance Information:** (Complete only if you will be using insurance. A copy of your insurance card will be required)

**Primary Insurance:** \_\_\_\_\_ Tel: \_\_\_\_\_  
**Insured's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Relation:** \_\_\_\_\_  
**Insured's Social Security#:** \_\_\_\_\_ **Policy ID#** \_\_\_\_\_ **Group#** \_\_\_\_\_

**Confidentiality:** Children respond better when therapeutic privacy is afforded. All communication between patient and psychologist will be held in confidence unless written consent for release is obtained from a parent, with few exceptions: psychologists are compelled by law to inform appropriate other person(s), including legal authorities, if there is evidence that a patient is in danger of creating serious bodily harm to self or someone else, or if there is reasonable suspicion a child has been abused. Records may also be released as a result of a court order. These situations have rarely occurred in my practice. Finally, some managed care plans require verbal and/or written treatment information from the care provider. If other members of the family participate in a session, they have rights to confidentiality as a collateral participant.

**Office Policies & Procedures:** Therapy sessions are 50 minutes, with rescheduling. Payment is due at the beginning of each session. The fee for one session is \$130. Other services, including telephone calls of more than 10 minutes, are charged at the same rate. You may use insurance, however, you remain responsible for any co-insurance, deductible or non-covered services. You will be charged a \$50 fee for all missed appointments unless you provide 24-hour advance notice, this is not covered by insurance. This office does not accept debit or credit cards. You will be charged a \$10 fee for each returned check. I am often not immediately available by telephone. Phone messages are returned by the next business day. If you are experiencing a crisis and need immediate assistance, you should call the local 24 hr. crisis hotline (480) 784-1500 or 911.

**Insurance Authorization & Receipt of Privacy Notice:** I authorize the above named insurance co. to make payments directly to Dr. Dan Short for services I receive. I have read the information regarding financial arrangements in the paragraph above. I understand that I am financially responsible for all charges incurred by me during the course of treatment, regardless of any insurance coverage I may have. I acknowledge that I have received a copy of the office's Notice of Privacy Practices. I have read and agree to the Office Policies and Procedures and Limits of Confidentiality.

**Consent for Treatment:** Formal consent is required before a psychologist can provide counseling or psychotherapy to a minor. By signing this form you are giving your consent for Dan Short, Ph.D., a psychologist licensed in the state of Arizona, to work with your child. The person signing this form must be the child's legal guardian.

\_\_\_\_\_  
Child guardian or legally authorized signature

\_\_\_\_\_  
Date